form of managed care bureaucracies and purchasing agencies to our current profligate arrangements.

The idea of using managed care to control health care costs was first embraced by the Nixon administration. Obviously, the rapid expansion of HMOs and other forms of managed care over the past 20 years has not slowed health inflation. The Congressional Budget Office recently concluded that the strategy was unlikely to have any favorable impact on health care costs for the next 5 years. It may, however, shift costs. Since 10% of the population consumes about 75% of the health care, the most effective way for insurers to be competitive (lowering their prices and enhancing their profits) is to avoid enrolling the sick or tending the chronically ill. Insurers who successfully elude the proposed ban on risk selection under the reform will accrue immense financial rewards, but costs in the system as a whole will remain unchanged.

Since managed competition doesn't control costs or reduce waste, the only way it will cover the uninsured is to increase health spending. Yet the United States already spends more than every other country on health care, over 30% more per capita than Canada spends to cover all its citizens under a single-payer system. In fact, health care is paradoxically the only domestic problem to which an abundance of resources (e.g., highly trained physicians, plenty of hospital beds, and sophisticated technology) has been committed, sufficient to assure all of us high-quality care. This is in sharp contrast to problems with our educational system, infrastructure, ecology, housing (to name but a few), which will require new billions to fix.

Accountability for health services in Canada rests with the provincial governments, which are responsible for providing health care for all and meeting the guidelines of the Canada Health Act. Each provincial plan must meet the following criteria:

1. Universal coverage "that does not impede . . . whether by charges made to insured persons, or otherwise, reasonable access"
2. Portability of benefits from province to province
3. Insurance for all medically necessary services
4. A publicly administered nonprofit program

The services are tax-financed, spreading the risk over the whole population and functioning as a form of social security in health care. The extraordinary popularity of the program is not limited to Canada: polls show that a clear majority of Americans would prefer government-financed national health insurance.

At this writing, the content of the Clinton proposal is yet to be revealed. There are several indications of some retreat from managed competition orthodoxy toward some single-payer principles. Thus, a global budget although anathema to the premises of managed competition, is said to be likely. Choice of provider is somehow to be assured, though just how this is to be accomplished in a world of super-HMOs challenges the imagination. Most interesting is the probable inclusion of a state option, permitting a choice between the two approaches, which would certainly generate a wholesome debate in many states.

The political process is moving toward a major modification of the health care system. Public health experience instructs us that a single-payer national health insurance plan can heal the dysfunctional contemporary system and spare us the vagaries, often cruel, of a marketplace gamble. The public health community has the responsibility to make this judgment known to the decision makers.

Our voice must be heard. □

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Community-Oriented Primary Care: The Legacy of Sidney Kark

The remarkable group of papers by Yach and Tollman,[1] Phillips,[2] and Susser[3] in this issue of the Journal trace, in compelling detail, a journey, which one author quite properly calls an odyssey. These papers speak to the seminal influence of one pioneer on health care reform as well as on the lives and careers of his students around the world. Collectively, they illustrate anew the fundamental association of health status with social, economic, and political circumstance, on the one hand, and the links between health care reform and broader political action and struggle, on the other.

The odyssey is the journey, across 5 decades and many continents, of a concept: community-oriented primary care, with a new institution—the community health center—as its instrument and means of implementation. The pioneer is Sidney Kark, fashioning the concept, creating the health centers in South Africa in the 1940s, and then, after interludes in the United States and at the World Health Organization in Geneva, developing that concept further in Israel.

One outcome among many is the network of community and migrant health centers in the United States. With nearly 7 million patients at some 2000 sites, this network has become a significant component of our health care system and a lifeline to people in poverty—those who are at greatest risk; who live in the most dangerous physical, social, and biological environments; and who thus bear the heaviest burdens of morbidity and mortality.

Simply put, community-oriented primary care is the merger of frontline clinical medicine with public health. At its best, it integrates personal curative and preventive medical services, demographic study, epidemiologic investigation, community organization, and health education.[4] Among its subsidiary themes are the organization of multidisciplinary family health teams serving defined populations, and the treatment of patients *and* community, as Susser notes, in the light of the biological *and* the epidemiological, social, and psychological sciences.[3]

A central tenet is that primary care should be rooted *in* communities, *for* communities, and *with* communities. The first proposal for the Office of Economic Opportunity–funded health centers in the United States noted that "the need is not for the distribution of services to passive recipients, but for the active involvement of local populations in ways which will change their knowledge, attitudes and motivation."[5] The proposal thus outlined the

Editor's Note. See related articles in this issue's Public Health Then and Now.

need for the formation of community health associations, which would ultimately own and control the local health centers.

These ideas had their roots in South Africa in Sidney and Emily Kark's work at the Pholela and Lamontville health centers and the Institute of Family and Community Health at the University of Natal Medical School in Durban. They reached back, as Yach and Tollman point out,[1] to the ideas of Engels and Virchow; they anticipated the resolutions at Alma-Ata.

There are some striking parallels in the South African and US health center experiences. Each derived in part from political action—the Alexandra, Pholela, and other South African health centers from the Gluckman Report[2] and resistance to apartheid and social inequity; the initial Mound Bayou (Mississippi) and Columbia Point (Boston) health centers from the civil rights movement and the War on Poverty. Each profited from early links with medical schools—Witwatersrand and Natal in South Africa; and Tufts, Rush, and the University of California at Los Angeles in the United States.

Each met with official resistance to innovation. In the 1940s, Kark was investigated for "communist activities" after distributing dried skimmed milk to malnourished children; in the 1960s, Mississippi officials labeled as "socialist" a program in which Delta Health Center physicians wrote prescriptions for food for malnourished families and arranged to have the prescriptions filled at local grocery stores and charged to the center's pharmacy budget. In the program's defense, I was moved to observe—as Kark doubtless had 2 decades earlier—that the specific therapy for malnutrition was food.

In South Africa, community-oriented primary care and all but a few health centers vanished with the access to power of a racist government. In the United States, during a succession of reactionary national administrations in the 1980s, community health centers suffered severe restrictions and cutbacks in their community-oriented outreach, health education, environmental, and social service activities.

Good ideas and concepts, however, may be rediscovered or reinvented—and may even flourish—in the face of urgent need, political upheaval, or both. In South Africa, as the accession to political power of the African National Congress approaches, the work of the Karks and their successors is now recalled, and the relevance of community health centers is appreciated as a possible centerpiece of the new national health care system that must soon emerge. In the United States, health centers are slowly but steadily being added to the undergraduate teaching sites of medical schools; the American Academy of Family Medicine now requires explicit training in community-oriented primary care as a condition for approval of its residency programs, and some medical schools are developing community-oriented primary care curricula. With a new national administration, there is reason to hope for an expansion of the health center network and a return to its original broad mandate.

And there is perhaps reason to hope for something further. In the United States in the 1960s, health centers were idealistically (and, perhaps, grandiosely) conceived by their originators as instruments of social change, a means of intervention in the social, biological, physical, and even political environments that so greatly determine the health status of the oppressed and disadvantaged in the first place.[6,7] The organization of poor communities and the management and control of their own health services is a first step toward empowerment.

Virchow argued that change in the social order was essential for lasting improvement in the health of poverty-stricken communities. Kark's work stands on Virchow's shoulders. The histories recounted in this issue of the Journal suggest how many of those who now work in social medicine owe a similar debt to Sidney and Emily Kark. □

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